



H229

**Authorization for Baptist Health
To Disclose Information to Others**

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of records from Baptist Health to the organization listed below:

Name: _____

Address: _____

Phone: _____

Dates of Service for Request _____

Format _____ Paper _____ Electronic

Information Requested

_____ Summary Report (diagnostic results and physician notes)

_____ Entire Medical Record

_____ Operative/Pathology Report

_____ Lab/X-Ray

_____ Medication Records

_____ Immunization Records

_____ Other _____

_____ EKG

The purpose of this request is

_____ Medical Care _____ Insurance _____ Personal Records _____ School/Work _____ Legal _____ Other

I understand that I may revoke this authorization at any time by sending a written notice to the address above. I understand that any release which has been made prior to such revocation and which was made in reliance upon this authorization shall not constitute a breach of my privacy rights. I understand that my ability to receive treatment is not conditioned on my signing this form. NOTICE: This authorization will expire in one year. Once information has been disclosed in accordance with this authorization, it may be re-disclosed to individuals or organizations that are not subject to HIPPA.

Signature of Patient or Legal Representative Date_____
Relationship, if not the patient**SPECIFIC INFORMATION FOR RELEASE OF DRUG/ALCOHOL ABUSE INFORMATION AND/OR MENTAL HEALTH INFORMATION**

I acknowledge that the information released MAY INCLUDE material that is protected by Federal law. My additional signature authorizes release of such information.

Signature of Patient or Legal Representative Date_____
Relationship, if not the patient

This form can be mailed or faxed to BHMC- Little Rock Attn: Medical Records Department 9601 Baptist Health Drive Little Rock, AR 72205.
Phone (501) 202-1914, Fax (501) 202-1249.

Revision Date: December 2023

Approved by: Systems Forms Committee